babies) given infusions of the drug for pre-eclampsia.[7] It therefore seems possible, but is not proved, that therapeutic doses of chlormethiazole may predispose old people to hypothermia. However, whether chlormethiazole is any better or worse than other hypnotics in this respect is not known, and some research is needed.

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[1] Jakobsson, S V, and Möller, M, *International Microform Journal of Legal Medicine*, 1972, **8**, 150.
[2] Oliver, J S, and Stewart, P D, *Medicine, Science and the Law*, 1975, **15**, 67.
[3] Horder, J M, *British Medical Journal*, 1978, **1**, 693.
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[6] Astra Chemicals Limited, *Heminevrin and its Application to Geriatrics, Alcoholism, Psychiatry, Pre-eclampsia and Other Convulsive States*. Watford, Astra.
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Mechanical aids to ventilation for use in the field

SIR,—Dr R Greenbaum (13 October, p 937) has suggested that time-cycled automatic ventilators may have advantages in allowing cardiac massage to synchronise with artificial ventilation. Most resuscitation training programmes stick to the American Heart Association (AHA) guidelines[1] by recommending massage at 60 compressions/min with a breath interposed every fifth without pausing. When a mechanical ventilator is used a high flow rate is essential in order to comply with this routine.

If the AHA guidelines are to be accepted, then the minimal gas flow rate required of a ventilator must be at least 60 l/min (100 l min has been agreed by both American and Australian standards committees). There is currently no time-cycled machine with a gas flow rate approaching 60 l/min.

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[1] American Heart Association, *Journal of the American Medical Association*, 1974, **227**, No 7 (suppl).

Breathing difficulties in the newborn

SIR,—Dr H B Valman states in his article (8 December, p 1483) that "antibiotics have no place in the treatment of respiratory distress syndrome, but some infants may need antibiotics as the group B streptococcus may produce a clinical picture similar to that of severe respiratory distress syndrome." I would agree with the second part of this statement, and our own experience in a unit caring for some 2500 deliveries a year is that we have had five babies in 1979 with fatal group B streptococcal infection. The illness of two of these and of one (who survived) with group D septicaemia masqueraded as hyaline membrane disease.

As a result of our own experience and that of other units we have changed our policy and, as Roberton suggests,[1] "give all dyspnoeic infants a course of benzylpenicillin for at least 48 hours until cultures are known to be negative, unless some clearly non-infectious condition like pneumothorax or congenital malformation is responsible for the dyspnoea." That prophylaxis against early-onset group B streptococcal septicaemia does result in the saving of some lives has been very strongly suggested by the outcome of a study by Lloyd *et al.*[2] I feel that now few paediatricians with responsibilities for neonates would agree with the first part of Dr Valman's statement.

On the subject of meconium aspiration, Dr Valman might have stated that at the very least a wide-bore catheter should be passed through the glottis and meconium sucked out. There seems little doubt that with efficient early management hardly any babies with this condition will need to be ventilated.

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[1] Roberton NRC. *Arch Dis Child* 1979;**54**:838-44.
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Aggressive patients—what is the answer?

SIR,—First of all, may I thank you for publishing my controversial letter on aggressive patients (3 November, p 1147). It attracted much publicity in the lay press and eventually culminated in my appearance on Scottish television with an eminent Glasgow family doctor on 20 November. During our discussion, it was agreed that there was abuse of the National Health Service facilities, including doctors, in most parts of the country by a minority of patients, which was affecting the morale of many general practitioners and, indirectly, the medical care of the majority of patients. The emphasis was placed mostly on health education to make people realise that it is in their interest to use responsibly the facilities provided by the National Health Service, which perhaps is the best in the world from the patients' point of view.

How do we go about educating the public? I wonder whether it might be a good idea to have some kind of association including representatives of patients and doctors, to improve communications from every point of view. General practitioners should acquaint patients with the workings of the Health Service and its limitations, and how unnecessary and excessive demands can affect the care of those who really need it. Patients, on their part, would have the opportunity to explain their grievances—to which, of course, we should be quite open. I am sure that a responsible attitude by the patient to his own health, correct interpretation of his rights, an insight into the problems facing the general practitioner, and the realisation how his own behaviour can affect the quality of treatment can all go a long way in making for a better Health Service and at the same time conserve our valuable resources, both human and financial.

Every day we are reminded that the country is facing an economic crisis, with the worst yet to come, and with every public service facing cuts in expenditure. It is therefore time that we all did our share in working out how best to utilise the available resources and eliminate indiscriminate consumption. I feel that very few of us cannot spare an hour every week for what I believe is a worthwhile cause, and I hope that some of my colleagues will think likewise.

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Unwanted journals

SIR,—As a mailing house that handles many free-circulation medical journals, I was interested to see the correspondence in your columns recently (6 October, p 867; 3 November, p 1149) concerning unwanted journals.

Although our role is merely to provide a mailing list to the specification of the individual publisher, we always take care not to include those doctors who do not want to receive a particular journal, provided that such a request has been passed on to us by the publisher concerned. Perhaps I might be permitted the comment that in our experience few doctors take the opportunity of saying "No" when sent a request card, and indeed most of your correspondents have returned "Yes" cards for specific journals according to our records.

Your readers may also care to note that we mail the following journals and correspondence should therefore be directed to ourselves and not the Medical Mailing Company as suggested by Dr Sam Rowlands (3 November, p 1149): *Pulse*, *Update*, *Medicine*, *Medisport*, *Hospital Update*, *On Call*, *Hospital Doctor*, and *World Medicine*.

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Amnesty International's medical group

SIR,—Amnesty International, a worldwide organisation founded in Britain in 1961, has become an acknowledged defender of the human right to hold and express convictions without threat of torture or persecution. Unfortunately, its scope is steadily widening with the increasing number of individuals hounded, jailed, and tortured in countries of every political hue—for maintaining their political, religious, scientific, or artistic opinion.

A medical group was established within the British section of Amnesty International about a year ago, with the purpose of assisting the organisation's objectives wherever the health of the persecuted is concerned. Its functions are: (1) To advise the Amnesty International research department, by assessing damage to the internee's health during and after imprisonment and torture; reliable reports are scrutinised and whenever possible the victim is examined. (2) To exert pressure on health authorities and members of the medical profession in the countries concerned to provide all necessary care for the maintenance of the physical and mental health of all prisoners; and also to avoid any participation in the penal process, particularly in torture; within this frame must be included the spurious psychiatric treatment of dissenters. (3) Research on the sequelae of imprisonment

and torture. (4) Establishing a network of prominent medical experts in the world who could influence their colleagues in countries acting in breach of the Helsinki agreement to stand firm on the side of human rights.

We would welcome any volunteers sympathising with our aims as new members of Amnesty International's medical group. If, however, any sympathisers feel that they cannot fully participate, on account of their present commitments, we would be grateful for help with an occasional case where the authority of a particular specialist might be of value. We would like to extend this invitation to members of the dental and nursing professions.

Please write to: London Region Medical Group, British Section, Amnesty International, 8-14 Southampton Street, London WC2E 7HF.

J POLLERT
Medical Adviser to London Office of the International Secretariat

ELIZABETH M GORDON
Co-ordinator, London Region Medical Group

Amnesty International, British Section, London WC2E 7HF

Medical audit and clinical competence

SIR,—At the recent meeting of the National Association of Clinical Tutors a straw poll was taken on the question of whether clinical tutors should act as "catalysts" in promoting educational opportunities in their hospitals which could be construed as instituting medical "audit." During the discussion it was accepted that some form of "audit" of a doctor's continuing competence to practise was desirable and that in the first instance this should probably take the form of encouraging clinical case discussions. In the preceding debate the word audit seemed to be used to denote peer review, quality of patient care, cost effectiveness, and clinical competence as well as that instilled professionalism of doctors which has *always* involved a willingness to learn and an anxiety to ensure that personal standards are at least average.

One of the most important ways by which this is achieved is co-operative discussion with colleagues about the management of patients. To refer to this process, which should be absolutely inherent in a doctor's professionalism, by a catchy, new, and misleading name and to suggest that this process may partially placate the supposed demands, legitimate or not, for some form of definable assessment of a doctor's continuing competence is at the best deluding and at the worst deceiving. To proclaim the growth of clinical meetings as part of the new process of "audit" and imply that this is in some way praiseworthy is surely wrong. So much should this process be assumed that we should positively refrain from proclaiming that it may be lacking in some institutions. By agreeing to institute any form of audit we implicitly acknowledge that the need for it exists, whereas we should perhaps be vigorously denying its need rather than appeasing by a process which should be an unquestioned part of continuing self-criticism.

We should realise that audit as generally understood denotes the process of identifying individuals whose standards of practice fall below the minimum acceptable to the majority. It has little or nothing to do with promotion of the highest standards of competence, which should be the main aim of medical educators, and little to do with the clinical competence of the majority of doctors.

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Multidisciplinary teams

SIR,—One might take issue with several points in the article by Drs James Appleyard and J G Maden on multidisciplinary teams (17 November, p 1305) and your leading article on the same topic. However, I should like to draw attention to two specific areas.

In the first place, the concept of "a team" is used extremely loosely, to such an extent that it becomes virtually meaningless. In the first example cited by Drs Appleyard and Maden, for instance, "the team" consists of no more than two professionals—who do not necessarily work together on a regular basis but who from time to time must reach agreement on a clinical matter. My edition of the Oxford Dictionary defines a team as "two or more beasts of burden harnessed together; set of persons working together." It is the idea of a group of people bounded by a common purpose who regularly come together to work and to fulfil their task that is central to the concept of a team.

In the second place, it is stated that clinical management by consensus does not work; that "it is impossible for a team to carry out any form of treatment or social work with an individual patient"; and that a multidisciplinary team cannot be "the hand that gives the pill." I have in fact recently reviewed the first eight months' work of a pilot study that has been carried out in this department with a small group of chronic psychiatric patients which directly contradicts these statements. In the course of this study, each of these patients was seen jointly, on an outpatient basis, by a social worker, a community nurse, and myself on from one to five occasions. In addition, these patients were seen individually by at least one of us. Chronic psychiatric outpatients are often seen by workers of different disciplines at different times for overlapping reasons and an important advantage of this joint approach was that management could be discussed concurrently by all the workers concerned, often together with the patient. The managements of these patients' neurotic and social problems were enhanced by this team method, while a recent spell of inpatient care and poor compliance with treatment were felt to be indications for individual management by a psychiatrist.

In general, the multidisciplinary team can enhance the clinical work of individuals, but can probably never replace it. Like any other clinical method, the team approach to management has its indications and its contraindications. Like other methods, it is also liable to abuse. In particular, the practitioner—of whatever discipline—can hide behind the team in an attempt to avoid individual responsibility. The team may be used to "blur roles," as a defence against envy and competition between disciplines, rather than as a means of sharing professional skills. At worst, people working in teams may become preoccupied with internal issues rather than the needs of the community they are meant to serve. These abuses must obviously be guarded against—ensuring that only part of an individual's clinical work is carried out as a member of a team is one way of doing this—but are no reason to reject multidisciplinary teams out of hand.

There should be careful study and evaluation of the contribution that teamwork can make to clinical practice, aided by clear thinking about the concepts and issues involved. Neither uncritical acceptance nor emotive rejection of teams, or the staunch defence of the rights of doctors, is a valid substitute. Furthermore, working in a multidisciplinary team is a skill which, like other skills, requires training and practice in order to be applied effectively.

T PASTOR

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SIR,—The highly topical article on multidisciplinary teams by Drs James Appleyard and J G Maden (17 November, p 1305) raises important issues. As a consultant psychiatrist with responsibility for the Wilton Unit, an outpatient group psychotherapy unit which is staffed by a multidisciplinary team consisting of four nurses, a social worker, a clinical psychologist, a lay group analyst, two part-time occupational therapists, and a sessional drama therapist (voluntary), I would like to share my own experience of the multidisciplinary team.

We take up to 18 severely disturbed neurotic patients for a time-limited period of 12 weeks in a daily group psychotherapy programme. I spend three sessions weekly in this unit and it is clearly emphasised to both patients and staff that I am clinically responsible for all patients admitted. Signing of sick notes and prescribing are my total responsibility. We do, however, aim to produce an agreed policy in the treatment programme; but should this fail to be agreed there is an overt understanding that the final decision is mine.

At the weekly policy meeting, which has a rotating chairman, policy for the unit is hammered out. The full agenda is submitted by members of staff, and this meeting has top priority in the work programme. It covers matters concerned with the weekly treatment programme, admission, discharge, and the role of the staff members in their differing disciplines; and their specialist points of view are encouraged. Only once in six years has there been an occasion when I overruled a dissident sister. At a further weekly meeting all patients are individually reviewed and their progress monitored. All referrals are accepted initially by me, but before full admission takes place assessment of each patient's suitability for treatment is fully discussed by the team. Some patients are "selected out" through an agreed policy made through the policy meeting.

In addition to these team meetings there is a weekly staff experimental group, led by a consultant colleague, where staff feelings as opposed to opinions are ventilated; these frequently concern anxiety and loss of role identity through the team approach. In this group we are also brought into touch with the power and reality of outside "masters" in our different disciplines, and are reminded that we are not an isolated treatment unit, but part of a wider and infinitely complex series of other systems in hierarchical order.

The National Health Service cannot afford the multidisciplinary team where the consultant abdicates ultimate responsibility for patient care in favour of a multidisciplinary